QuitlineNC
FAX REFERRAL FORM

Fax completed form to: 1-800-483-3114 **Date Fax Sent: __/__/____**

Provider Information:

Hospital-Clinic
(Facility) Name: _____ County _____

In order to receive a Participant's Outcome Report, you must be a HIPAA-Covered Entity

- I am a HIPAA-Covered Entity? (Please check one) ☐ Yes ☐ No ☐ I Don't Know
- I would like to receive a status report regarding this referral ☐ Yes ☐ No

Fax: (_____) _____ - _____ Person Referring:_____ Contact Phone: (_____) _____ - _____

Participant Information: Gender: ☐ Male ☐ Female Pregnant? ☐ Yes ☐ No

Participant
Name: _____ DOB: __/__/____

Address: _____ City: _____ Zip: _____

Best # to call: (____) _____ - _____Type: ___ Home ___ Work ___ CELL

Back-up # to call: (____) _____ - _____Type: ___ Home ___ Work ___ CELL

Language Preference (check one): ☐ English ☐ Spanish ☐ Other - _____

_____ (Initial) I am ready to quit tobacco within 30 days and request QuitlineNC to contact me to help me with my quit plan.

_____ (Initial) I **DO NOT** give permission to QuitlineNC to leave a message when contacting me.

Participant Signature: _____ **Date:** __/__/____

Check the BEST time for QuitlineNC to call you.

☐ **9am – 12pm** ☐ **12pm - 3pm** ☐ **3pm - 6pm** ☐ **6pm - 9pm** ☐ **9pm – 12am**

NOTE: The QuitlineNC is open 7 days a week; but call attempts to participants are only made until midnight. Also, calls made over the weekend may be made at times other than during this 3-hour time frame.

DOUBLE YOUR CHANCES OF QUITTING FOR GOOD